HEADQUARTERS, US ARMY MEDICAL COMMAND
Fort Sam Houston, TX 78234-6007
031445R JAN 07

OPERATION ORDER 07-34 (Re-engineering Systems of the Primary Care Treatment (of Depression and PTSD) in the Military – RESPECT MIL)

References:

a. "Re-engineering systems for the treatment of depression in primary care: cluster randomized controlled trial," BMJ, doi:10.1136/bmj.38219.481250.55.

b. "A Three-Component Model for Reengineering Systems for the Treatment of Depression in Primary Care," Psychosomatics 43:6, November-December 2002.

c. RESPECT-MIL Clinician Education Manual (Three Component Model for Primary Care Management of Depression and PTSD), by Thomas E. Oxman MD, Dartmouth Medical School, © May 2006 3CM™, LLC – Version 3.0.

d. RESPECT-MIL Care Manager Reference Manual (Three Component Model), by Thomas E. Oxman MD, Dartmouth Medical School, © May 2006 3CM™, LLC – Version 3.0.

Time Zone Used Throughout the Order: Romeo (Eastern Standard Time).

Task Organization:

1. SITUATION.

a. Re-engineering Systems of the Primary Care Treatment (of Depression and PTSD) in the Military (RESPECT-MIL) is a program that provides primary care-based screening, assessment, treatment, and referral of active duty (AD) personnel with depression and post-traumatic stress disorder (PTSD).

b. RESPECT-MIL includes universal training on primary care based-screening, assessment, and treatment for all Army primary care providers (PCPs) and RESPECT-MIL Facilitators (RMFs).

c. RESPECT-MIL also establishes a Center of Excellence (COE) at Womack Army Medical Center (WAMC), Fort Bragg, NC, with a designated primary care physician and psychiatrist to oversee implementation of the program across all sites.

(1) The COE has dual primary missions to oversee and implement training of the RESPECT-MIL Program to all relevant personnel (detailed below) and to facilitate and manage program implementation at designated sites.

(2) Accordingly, the COE will also facilitate and manage ongoing planning, sustainment, data collection, and program evaluation.

(3) The COE will report operational status on these issues to the RESPECT-MIL Program Director (RPD), who will direct its operations.

d. The RESPECT-MIL program has been piloted at a single clinic at Fort Bragg, NC, utilizing one RMF. Both provider and patient feedback indicated on-site presence of the RMF was highly valued. Implementing the program at multiple clinics at a given site with one RMF may, therefore, be challenging. This challenge will be addressed by targeting start-up clinics and implementing gradually across clinics at a given site and adding additional RMF resources, as needed.

e. Preparing sites for implementation, training its personnel, and beginning implementation at all 15 sites simultaneously would be challenging. Therefore, implementation will occur incrementally.

f. This order provides military decision makers with a brief recapitulation of the major aspects of RESPECT-MIL programs. This order is based on planning factors and estimates available at the time of preparation and is subject to modification in the context of the on-going RESPECT-MIL implementation. This information will likely require updating before the implementation of RESPECT-MIL at the identified Army sites.

2. MISSION. Effective immediately, MEDCOM initiates staged implementation of the RESPECT-MIL Program at 15 locations to provide primary care-based screening, assessment, treatment, and referral of active duty (AD) personnel with depression and post-traumatic stress disorder (PTSD).

3. EXECUTION.

Intent. MEDCOM will implement RESPECT-MIL and will fully support this program. Key is increasing the detection of depression and PTSD disorders, improving treatment access, facilitating continuity and coordination with specialty mental health services that lead to reducing symptom severity, and increasing PCP satisfaction and effectiveness when managing these diagnoses. End state is RESPECT-MIL fully implemented at each of the 15 locations as specified in this order.

a. Concept of Operations. The RESPECT-MIL Program will be implemented in four (4) phases. There will be ongoing evaluation for process improvement at each phase and at each site during site preparation, training, and implementation; there may be consequent adjustments to the implementation plan and timeline, accordingly. The key activities associated with each of the 4 phases are described below:

(1) Phase 1 – Site preparation. This phase will occur during the first year as outlined below:

JAN – JUN 2007	MAY – SEP 2007	AUG – DEC 2007
Fort Drum, New York	Fort Benning, Georgia	Fort Lewis, Washington
Fort Bragg, North Carolina	Fort Bliss, Texas	Schofield Barracks, Hawaii
Fort Campbell, Kentucky	Fort Polk, Louisiana	Vilseck, Germany
Fort Hood, Texas	Fort Riley, Kansas	Schweinfurt, Germany
Fort Stewart, Georgia	Fort Carson, Colorado	Vicenza, Italy

(a) An implementation message will be sent to affected AMEDD activities with a copy of this order.

(b) The OTSG RESPECT-MIL Project Officer (SGPO) and RESPECT-MIL Program Manager (RPD) will brief all AMEDD activities via video teleconference (VTC).

(c) COE will finalize assignments/ hires as outlined.

(d) COE staff and/or the RPD will conduct preliminary orientation briefings at targeted sites and Regional Medical Commands (RMCs), as required, to engage clinic staff, site leadership, and RMC leadership.

(e) In coordination with OTSG, RMCs, site medical treatment facilities (MTFs) and their site satellite clinics, COE will assess important variables at designated installations such as number of primary care clinics, number of AD enrollees and PCPs at each, number of associated battalion aid stations, sick call and regular clinic visits per month, extent of installation behavioral health and related psychosocial support resources, the degree of preexisting behavioral health resources integrated into primary care clinics, and the nature of specialty care programs specifically addressing depression and PTSD.

(f) Site MTF Commanders will select initial start-up clinics. Site medical commanders, in consultation with the COE and RMCs, will target clinics that have the highest active duty populations and populations with the most post-deployment health concerns. Other target criteria include staff and leadership enthusiasm about primary care-based screening and treatment of depression and PTSD, and effective working relationships with behavioral health resources. When program implementation at targeted start-up clinics is stable, program implementation will be expanded to additional installation clinics using prioritization criteria stated above.

(g) In coordination with OTSG Public Affairs Office, COE, and Three Component Model (3CM), RESPECT-MIL clinician and Soldier education/marketing materials will be developed and/or updated. RESPECT-MIL news releases will be

developed/ implemented. A core focus of the RESPECT-MIL education/marketing campaign will be to decrease the stigma of seeking treatment.

(h) Training manual and DVD/CD for installation RESPECT-MIL clinicians and RMFs will be revised and updated. Training plan will be further developed as required.

(i) Hiring of site RMFs and administrative assistants completed. The RMFs will be contracted through regional contracting services utilizing the Statement of Work (SOW) previously drafted by USAMEDCOM. While RMF performance will be supervised by the site PCP champion at each facility, the Chief Nurse of each installation will monitor nursing scope of practice. Site Administrative Assistants will be contracted through regional contracting offices utilizing a SOW drafted by USAMEDCOM.

(j) In coordination with COE and at the tasking of SGPO, site leadership will identify site provider "champions"; that is, a lead physician and lead Behavioral Health Provider (BHP). Clinical skill and motivation for the RESPECT-MIL program will be the most important qualifications.

(k) RESPECT-MIL clinical administrative forms and patient education materials will be updated and disseminated.

(l) The COE will write central program level operational instructions which will serve as the basis for clinic operational instructions at the site level. These operational instructions will include program fidelity checklists so that local leaders can monitor fidelity to the RESPECT-MIL program.

(m) The 3CM consultants have implemented RESPECT-MIL at several large healthcare organizations and multiple clinics. Therefore, the 3CM Team will consult intensively with the COE regarding all aspects of RESPECT-MIL implementation and training.

(n) The SGPO will maintain oversight and provide guidance/assistance at this and all subsequent phases of the RESPECT-MIL rollout.

(2) Phase 2 – Personnel training and initial implementation. This phase will occur during the first year as outlined below:

JAN – JUN 2007	MAY – SEP 2007	AUG – DEC 2007
Fort Drum, New York	Fort Benning, Georgia	Fort Lewis, Washington
Fort Bragg, North Carolina	Fort Bliss, Texas	Schofield Barracks, Hawaii
Fort Campbell, Kentucky	Fort Polk, Louisiana	Vilseck, Germany
Fort Hood, Texas	Fort Riley, Kansas	Schweinfurt, Germany
Fort Stewart, Georgia	Fort Carson, Colorado	Vicenza, Italy

(a) RESPECT-MIL training materials, education materials for clinicians and Soldiers, and news releases will be disseminated to targeted clinics and their staff.

(b) The RPD and COE will conduct 2-day RESPECT-MIL training workshops at Fort Bragg, NC. There will be three 2-day training sessions during the first year, one for each for the three phases of five sites to be rolled out during the first year. Attendees will be the RMFs, administrative assistants, lead physician, and lead BHP from each site. For the lead physician particularly, and also for the BHP, a "train-the-trainer" model will be utilized. These individuals will receive training and materials to successfully implement the program and to train relevant personnel (i.e., other PCPs and backup BHPs) at their home sites.

(c) Personnel who have successfully completed "the train-the-trainer courses" will then train relevant personnel at designated clinics at their home sites.

(d) Designated clinics prepare for implementation (e.g., incorporate screening, display awareness materials, develop staff and operational communications strategies/ protocols, supervision scheduling/ tactics, patient tracking, data collection, feedback mechanisms at the local level).

(e) Local level program leaders will write local operating instructions describing processes referred above. These local operating instructions will derive substantially from higher level operating instructions, written by the COE office, and reflect unique, clinic-specific issues/ processes not addressed in the higher level operating instructions. Local leaders will systematically assess their program adherence to the RESPECT-MIL program, utilizing fidelity checklists developed by the COE. Local leaders will consult with COE during this process.

(f) Trained trainers (i.e., lead physician and BHPs) establish an ongoing training program and begin implementation of it at the local level (e.g., for newly-assigned personnel). It is recommended that newcomer PCPs receive RESPECT-MIL training as part of their clinic orientation or clinic training program. The lead physician and BHP will oversee this process and ensure all newly-arriving PCPs are trained in a timely manner. Newcomer training will utilize RESPECT-MIL training materials, manuals, and videos disseminated previously.

(g) Designated sites begin implementing RESPECT-MIL in the manner described above.

(h) In consultation with COE, designated clinics begin collecting program evaluation metrics. Metrics will undergo early programmatic scrutiny and refinement to meet accountability and management objectives. There will be more focus on program evaluation in year two than year one, which is focused on training and implementing the

program at 15 sites. The COE will establish standardized metrics so as to achieve consistency and standardization of program evaluation tools across the sites. Some of the potential program metrics being considered at this time are:

(i) Total active duty population (active component (AC) and reserve component (RC)) at individual sites.

(ii) Number of patients screened.

(iii) Number and percent of clinic AD (AC and RC) population screened.

(iv) Number (percent) of patients screening positive for depression, PTSD, and for both.

(v) Number (percent) of patients screening positive who engage in RESPECT-MIL treatment.

(vi) Number (percent) of patients screening positive who engage in RESPECT-MIL treatment and care facilitation.

(vii) Number (percent) of patients screening positive who decline RESPECT-MIL and specialty care treatment and/ or referral.

(viii) Number (percent) of patients who screen positive, but are not referred for treatment, and the reasons why not referred (e.g., false positives, already engaged in sufficient care, patient declines referral).

(ix) Mean before-after treatment scores on Patient Health Questionnaire-9 (PHQ-9) measure of depression and PTSD Checklist (PCL) measure of PTSD symptom severity for closed cases.

(x) Percent of treated patients whose scores on PHQ-9 and PCL decrease to clinically insignificant range (i.e., below established thresholds) for closed cases.

(xi) Provider and patient satisfaction metrics.

(xii) Average duration of clinic treatment by diagnosis.

(xiii) Reasons for disenrollment—e.g., problem resolution, transfer to specialty care, premature treatment withdrawal, etc.

(i) The COE will establish mechanisms for ongoing physician and BHP champion, RMF, and administrative assistant supervision and education, utilizing telephonic and/ or video-telephonic technology. Mechanisms will include regular

individual or group telephonic, VTC, and/or on-site supervision of key RESPECT-MIL personnel (i.e., PCPs, BHPs, RMFs, and administrative assistants) by their COE counterparts. Group supervision/education may occur on a regional basis (e.g. SERMC, ERMC), phase (first, second, third phase sites rolled-out) or worldwide basis. COE will also facilitate supportive relationships between key personnel at designated sites amongst each other so as to facilitate local innovation, best practices, problem-solving, success stories, etc.

(j) Identified clinics will conduct quarterly standardized program evaluation reports, using metrics identified by the COE. These reports will be sent to the MTF Commander and COE. MTF commanders will provide quarterly reports to RMCs. RPD/ COE will provide quarterly reports to SGPO.

(k) RPD and COE continue trainings as needed/ desired at designated RESPECT-MIL clinics (e.g., for newly-designated/ hired clinic RMF, PCP, or BHP trained trainers, personnel who could not attend initial Fort Bragg training, etc.).

(l) COE will conduct regular staff assistance visits to RESPECT-MIL clinics as needed/requested.

(m) Site RESPECT-MIL leaders and COE monitor workload of RMFs and adjust RMF resources, as indicated.

(n) OTSG and SGPO will provide ongoing guidance/ direction as needed to RPD as RESPECT-MIL program is implemented over time and program evaluation data is analyzed. Means of recognizing sites/individuals which excel in RESPECT-MIL program implementation will be developed and administered.

(o) MTF and RMCs provide program implementation oversight and monitoring.

(3) Phase 3 – Training Program for Army PCPs. Education of PCPs throughout the Army (i.e., beyond RESPECT-MIL sites) will begin the first year and continue throughout the second year.

(a) Under the direction of SGPO, AMEDDC&S will coordinate with RPD, COE (with consultation from 3CM) and the Family Medicine and Behavioral Health Consultants to The Surgeon General to develop training materials and a training plan on depression, PTSD, and RESPECT-MIL for PCPs throughout the Army.

(b) The purpose of the training will be to enhance PCPs ability to assess and treat depression and PTSD in a primary care environment and to understand systemic changes which foster effective primary care management of these disorders.

(c) AMEDDC&S will coordinate with RPD, COE, and Family Medicine and Behavioral Health Consultants to The Surgeon General to develop training plan/ materials for PCPs trained in residence at the AMEDD C&S (e.g., physician assistants).

(d) AMEDDC&S will coordinate with RPD, COE and the Family Medicine and Behavioral Health Consultants to The Surgeon General to develop training plans/materials for PCPs who do not attend the AMEDDC&S training in residence described above or who do not receive RESPECT-MIL training because they have positions at one of the 15 RESPECT-MIL sites.

(e) A variety of training modalities to meet this mission will be explored and developed (e.g., regional or worldwide VTC training, web-based training, live training workshops at Army/ DoD professional medical workshops).

(f) RPD and COE, with substantial input from 3CM, will coordinate with AMEDDC&S to assist with the development of training materials for PCPs who cannot receive live training.

(g) AMEDDC&S will coordinate with Family Medicine Consultant to The Surgeon General to develop means to ensure that all Army PCPs receive this training.

(h) AMEDDC&S will develop training plans/ materials during the first six months of RESPECT-MIL year one implementation, begin implementing training programs thereafter, and will have trained all Army PCPs at the end of two years.

(i) AMEDDC&S will coordinate with RPD, COE and Family Medicine and Behavioral Health Consultants to The Surgeon General to develop an ongoing training program for newly accessed PCPs in the future.

(4) Phase 4 – Ongoing Implementation, Evaluation, and Transfer of Operational Control to OTSG. Ongoing sustainment, evaluation and transfer of operational control to OTSG will occur during the second year.

(a) Designated clinics will continue program implementation, local training, and evaluation/reporting as described in Phase 2.

(b) RPD/ COE will continue training and staff assistance visits as needed/ required, program monitoring, evaluation/analysis, and reporting.

(c) MTFs and RMCs will continue oversight and monitoring with COE consultation.

(d) SGPO will continue to provide oversight, guidance and direction.

(e) RPD/ COE coordinates and consults with AMEDD leadership to transfer full management of RESPECT-MIL Program to newly established AMEDD RESPECT-MIL Program Office at OTSG. OTSG SGPO will provide oversight and direction to this Program Office.

b. Tasks to Subordinate Units.

(1) NARMC.

(a) NLT 30 JUN 07, implement RESPECT-MIL at the following sites:

(i) Fort Drum, New York

(ii) Fort Bragg, North Carolina

(b) With assistance from the COE, develop an implementation strategy and provide supporting OPORD to the SGPO NLT 30 MAR 07.

(2) SERMC.

(a) NLT 30 JUN 07, implement RESPECT-MIL at the following sites:

(i) Fort Campbell, Kentucky

(ii) Fort Stewart, Georgia

(b) NLT 30 SEP 07, implement RESPECT-MIL at Fort Benning, Georgia.

(c) With assistance from the COE, develop an implementation strategy and provide supporting OPORD to the SGPO NLT 30 MAR 07.

(3) GPRMC.

(a) NLT 30 JUN 07, implement RESPECT-MIL at the following site:

(i) Fort Hood, Texas

(b) NLT 30 SEP 07, implement RESPECT-MIL at the following sites:

(i) Fort Bliss, Texas

(ii) Fort Polk, Louisiana

(iii) Fort Riley, Kansas

(iv) Fort Carson, Colorado

(c) With assistance from the COE, develop an implementation strategy and provide supporting OPORD to the SGPO NLT 30 MAR 07.

(4) WRMC.

(a) NLT 31 DEC 07, implement RESPECT-MIL at Fort Lewis, Washington.

(b) With assistance from the COE, develop an implementation strategy and provide supporting OPORD to the SGPO NLT 30 MAR 07.

(5) PRMC.

(a) NLT 31 DEC 07, implement RESPECT-MIL at Schofield Barracks, Hawaii.

(b) With assistance from the COE, develop an implementation strategy and provide supporting OPORD to the SGPO NLT 30 MAR 07.

(6) ERMC.

(a) NLT 31 DEC 07, implement RESPECT-MIL at the following sites:

(i) Vilseck, Germany

(ii) Schweinfurt, Germany

(iii) Vicenza, Italy

(b) With assistance from the COE, develop an implementation strategy and provide supporting OPORD to the SGPO NLT 30 MAR 07.

(7) AMEDDC&S.

(a) During Phase 3 and under the direction of SGPO, coordinate with RPD, COE (with consultation from 3CM) and the Family Medicine and Behavioral Health Consultants to The Surgeon General to develop training materials and a training plan on depression, PTSD, and RESPECT-MIL for PCPs throughout the Army.

(b) During Phase 3 coordinate with RPD, COE, and Family Medicine and Behavioral Health Consultants to The Surgeon General to develop training plan/ materials for PCPs trained in residence at the AMEDD C&S (e.g., physician assistants).

(c) During Phase 3 coordinate with RPD, COE and the Family Medicine and Behavioral Health Consultants to The Surgeon General to develop training plans/materials for PCPs who do not attend the AMEDDC&S training in residence described above or who do not receive RESPECT-MIL training because they have positions at one of the 15 RESPECT-MIL sites.

(d) During Phase 3 coordinate with Family Medicine Consultant to The Surgeon General to develop means to ensure that all Army PCPs who cannot receive live training receive appropriate training materials

(e) During Phase 3 develop training plans/ materials during the first six months of RESPECT-MIL implementation, begin implementing training programs thereafter, and train all Army PCPs within two years.

(f) During Phase 3 coordinate with RPD, COE and Family Medicine and Behavioral Health Consultants to The Surgeon General to develop an ongoing training program for newly accessed PCPs in the future

(8) Center of Excellence (COE), Womack Army Medical Center (WAMC).

(a) During Phase 1, finalize assignments/ hires as outlined.

(b) In coordination with the RPD during Phase 1, conduct preliminary orientation briefings at targeted sites and Regional Medical Commands (RMCs). as required, to engage clinic staff, site leadership, and RMC leadership.

(c) During Phase 1 and in coordination with OTSG, the RMCs, site medical treatment facilities (MTFs) and their site satellite clinics, assess important variables at designated installations such as:

(i) Number of primary care clinics.

(ii) Number of AD enrollees and PCPs at each.

(iii) Number of associated battalion aid stations.

(iv) Sick call and regular clinic visits per month.

(v) Extent of installation behavioral health and related psychosocial support resources.

(vi) Degree of preexisting behavioral health resources integrated into primary care clinics.

(vii) Nature of specialty care programs specifically addressing depression and PTSD.

(d) In coordination with OTSG PAO and 3CM during Phase 1, develop and/ or update RESPECT-MIL clinician and Soldier education/marketing materials.

(e) During Phase 1 and in coordination with site leadership and at the tasking of SGPO, ensure site leadership identifies site provider "champions."

(f) During Phase 1, write central program level operational instructions which will serve as the basis for clinic operational instructions at the site level. These operational instructions will include program fidelity checklists so that local leaders can monitor fidelity to the RESPECT-MIL program.

(g) In coordination with RPD, conduct three RESPECT-MIL training workshops at Fort Bragg, NC. These will be 2-day training sessions.

(h) In coordination with designated clinics, begin collecting program evaluation metrics during Phase 2.

(i) During Phase 2, establish standardized metrics so as to achieve consistency and standardization of program evaluation tools across the sites.

(j) During Phase 2, establish mechanisms for ongoing physician and BHP champion, RMF, and administrative assistant supervision and education, utilizing telephonic and/ or video-telephonic technology.

(k) During Phase 2, facilitate supportive relationships between key personnel at designated sites amongst each other so as to facilitate local innovation, best practices, problem-solving, success stories, etc.

(l) In coordination with RPD, provide quarterly standardized program evaluation reports to SGPO.

(m) In coordination with RPD, continue trainings as needed/ desired at designated RESPECT-MIL clinics.

(n) Conduct regular staff assistance visits to RESPECT-MIL clinics as needed/requested.

(o) In coordination with site RESPECT-MIL leaders, monitor workload of RMFs and adjust RMF resources, as indicated.

(p) In coordination with RPD and with substantial input from 3CM, coordinate with AMEDDC&S to assist with the development of training materials for PCPs who cannot receive live training.

(q) During Phase 4 and in coordination with RPD, continue training and staff assistance visits as needed/ required, program monitoring, evaluation/ analysis, and reporting.

(r) During Phase 4 and in coordination with RPD, coordinate and consult with AMEDD leadership to transfer full management of RESPECT-MIL Program to newly established AMEDD RESPECT-MIL Program Office at OTSG. OTSG SGPO will provide oversight and direction to this Program Office.

(s) Assist RMCs in developing implementation strategies to facilitate their providing supporting OPORDs to the SGPO NLT 30 MAR 07.

c. Tasks to Staff.

(1) OTSG Public Affairs.

(a) In coordination with COE and 3CM during Phase 1, develop and/ or update RESPECT-MIL clinician and Soldier education/marketing materials

(b) During Phase 1, develop/ implement RESPECT-MIL news releases

(c) During Phase 1, ensure the core focus of the RESPECT-MIL education/ marketing campaign is to decrease the stigma of seeking treatment

(2) OTSG RESPECT-MIL Project Officer (SGPO) (COL Ritchie).

(a) In coordination with RPD and during Phase I, brief all AMEDD activities via video teleconference (VTC).

(b) During Phase 1 and in coordination with site leadership and COE, task site leadership to identify site provider "champions."

(c) Maintain oversight and provide guidance/ assistance during all stages of the RESPECT-MIL rollout.

(d) In coordination with OTSG, provide ongoing guidance/ direction as needed to RPD as RESPECT-MIL program is implemented over time and program evaluation data is analyzed.

(e) Develop and administer appropriate recognition to those sites/individuals that excel in RESPECT-MIL program implementation.

(f) During Phase 3, continue to provide oversight, guidance and direction.

(g) Once established, provide oversight and direction to the AMEDD RESPECT-MIL Program Office at OTSG.

(h) Oversee the RPD and relevant RMCs to ensure proper program oversight and monitoring and will provide program direction and guidance.

(i) Track all suspenses annotated in this OPORD and report status to OPS21 and copy furnish the RPD.

(3) RESPECT-MIL Program Director (RPD) (COL Engel).

(a) In coordination with SGPO and during Phase I, brief all AMEDD activities via video teleconference (VTC).

(b) In coordination with COE staff during Phase 1, conduct preliminary orientation briefings at targeted sites and Regional Medical Commands (RMCs), as required, to engage clinic staff, site leadership, and RMC leadership.

(c) In coordination with COE, conduct three RESPECT-MIL training workshops at Fort Bragg, NC. These will be 2-day training sessions.

(d) In coordination with COE, provide quarterly standardized program evaluation reports to SGPO.

(e) In coordination with COE, continue trainings as needed/ desired at designated RESPECT-MIL clinics.

(f) In coordination with COE and with substantial input from 3CM, coordinate with AMEDDC&S to assist with the development of training materials for PCPs who cannot receive live training.

(g) During Phase 4 and in coordination with COE, continue training and staff assistance visits as needed/ required, program monitoring, evaluation/ analysis, and reporting.

(h) During Phase 4 and in coordination with COE, coordinate and consult with AMEDD leadership to transfer full management of RESPECT-MIL Program to newly established AMEDD RESPECT-MIL Program Office at OTSG. OTSG SGPO will provide oversight and direction to this Program Office.

d. Coordinating instructions.

(1) This order is effective upon receipt.

(2) The basic RESPECT-MIL protocol consists of the following procedures which are detailed in RESPECT-MIL Facilitator and Clinician Edition training manuals (see ANNEX V (Clinician RESPECT-MIL Manual) and ANNEX W (RESPECT-MIL Facilitator Manual)) and will be detailed further in program-level operating instructions.

(a) All AD patients are screened for depression and PTSD using a 6-item questionnaire as part of the clinic check-in and vital signs assessment at designated primary care clinics. These screenings may occur in battalion aid stations or in regular primary care clinics, but will occur at a point of direct care.

(b) Individuals who screen positive will complete additional symptom severity and presumptive diagnostic tools. These results are given to the PCP who will interview the Soldier. Patients who screen positive and, during the interview, appear to have a disorder are informed of treatment options and, based on patient preferences and clinical considerations, a treatment option is selected. The treatment options are watchful waiting, treatment and care facilitation in primary care, referral to specialty care for evaluation and treatment, which may also include concurrent PCP treatment and care facilitation. At screening or in the course of treatment, patients may also be informed of or referred to non-medical help options such as Military One Source, the Chaplaincy, and Army Community Services programs. Some patients with more severe or emergent symptoms will be referred directly to behavioral health specialty care and will not be engaged in RESPECT-MIL primary care-based treatment/care facilitation. The reasons for declination of some kind of treatment will be categorized and documented for patients who decline treatment and they will be engaged in a watchful waiting process. Screen positives who do not have a disorder (false positives) may engage in a watchful waiting process or a prevention-focused primary care-based intervention and care facilitation, depending on patient preferences and clinical considerations.

(c) Patients with presumptive depressive or PTSD disorders, or another unmet psychiatric need, who are selected and have consented to be followed in primary care, are referred to the RMF. The RMF schedules future phone contacts at one week and every four weeks, thereafter (with more frequent calls being scheduled as needed clinically). RMFs monitor treatment adherence, side effects, and response to treatment, using symptom severity questionnaires and communicate these findings to the patients' PCPs and consulting BHPs (described further below). They also help the patient problem solve difficulties with treatment adherence.

(d) The RMFs receive weekly supervision of caseload by the BHP and communicates the BHP recommendations to the PCP. The BHP may also communicate directly with the PCP and vice versa. Overall, the RMF's role is to extend the PCP's treatment effectiveness via increasing the frequency of patient contact, systematic monitoring and intensive BHP input to treatment via systematic supervision and liaison with the BHP.

(e) The goals of treatment coupled with RESPECT-MIL care facilitation are reduced symptom severity below a clinically significant threshold and effective continuity of care. Treatment and nurse RESPECT-MIL care facilitation will generally last until these goals are comfortably achieved, as long as there is steady progress and/ or there is a need for enhanced healthcare continuity. Both depression and PTSD can often be chronic and thus, treatment may at times be of long duration. A major goal is effective continuity of care and therefore RMFs should not be artificially limited to a specific number of follow-up visits.

(f) Patients who demonstrate insufficient progress or response, or who develop complications (e.g., suicide attempt), will be referred to specialty behavioral healthcare. The RMF's role in such cases is to facilitate referral completion.

(g) Clinic leaders will need to develop consensus on respective RMF/ BHP roles (e.g., through memorandums of understanding) in clinics that have pre-existing behavioral health resources integrated into primary care (i.e., BHPs working in the primary care clinic). Generally, the RMF should continue care facilitation and liaison between the PCP and RESPECT-MIL BHP, while the integrated BHP's role should be treatment-oriented (vs. care facilitation or consultation-oriented).

(3) Regional Medical Commands (RMCs) will maintain oversight of RESPECT-MIL implementation at the sites under their command.

(a) With assistance from the COE, RMCs will develop an RMC implementation strategy.

(b) RMCs will provide their supporting OPORDs to the SGPO NLT 30 MAR 07. The COE will provide assistance to relevant RESPECT-MIL sites in development of their OPORD.

(4) Medical Treatment Facility (MTF) Commanders at the 15 designated sites will be responsible for RESPECT-MIL implementation at their sites. In consultation with the RESPECT-MIL COE, and consistent with the RESPECT-MIL program guidance, MTFs will develop a strategy for implementation. At the site level, implementation should occur in a phased fashion.

(a) Initial implementation will be targeted toward clinics that serve the greatest number of recently deployed active duty populations (i.e., are likely to have the greatest need).

(b) Implementation will expand to other clinics and populations after operations at targeted clinics are stable.

(c) In addition to the major criteria of a high number of recently deployed Soldiers, other important criteria for clinic selection include enthusiastic clinic leadership and good working relations with Behavioral Health resources.

(5) The RESPECT-MIL team at the site level will consist of a lead Primary Care Physician, a lead BHP, an RMF and an administrative assistant. Because the BHP will be providing supervision and consultation to the RMF and PCPs on pharmacological (as well as other behavioral health issues), it is preferable that the BHP be a psychiatrist. However, if there are local resource challenges, a clinical psychologist or clinical social worker may serve in this role.

(6) The lead PCP at designated sites will be the team leader.

(7) Force Requirements. RESPECT-MIL requires:

(a) Office of The Surgeon General (OTSG) Project Officer (SGPO). The SGPO provides the overall direction and guidance for the RESPECT-MIL program and the RPD. In addition, the SGPO serves as the interface with relevant parties and offices implementing the RESPECT-MIL program. Direction and guidance will be provided to the RPD (see below) who will coordinate and consult with the Family Medicine and Behavioral Health Consultants to The Surgeon General.

(b) Center of Excellence (COE).

(i) RPD. The RPD will implement program guidance and direction and report program status to the SGPO. RPD will provide program direction through the COE, to be established at Womack Army Medical Center (WAMC). The RPD will coordinate and consult with the Family Medicine and Behavioral Health Consultants.

(ii) Three Component Model Team (3CM Team). Subject matter experts associated with the RESPECT-MIL program from Dartmouth and Duke Universities will provide consultative services and help design the program evaluation. These investigators will continue to coordinate with the RPD and COE, providing ongoing consultation, training, implementation, enhancement, and materials and ongoing intellectual support. These consultants will be referred to as the "3CM Team."

(iii) Primary Care Program Manager (AOC 61F or 61H), COE at WAMC, will be trained and experienced in implementing the RESPECT-MIL protocol. This individual will serve as a full-time program administrator and trainer and will be substantially involved in training respective discipline members at designated sites and in monitoring and guiding RESPECT-MIL implementation (i.e., distance supervision).

(iv) Psychiatrist Program Manager (AOC 60W), COE at WAMC, will be trained and experienced in implementing the RESPECT-MIL protocol. Serving as a full-time program administrator and trainer, he or she will be substantially involved in training respective discipline members at designated sites and in monitoring and guiding RESPECT-MIL implementation (i.e., distance supervision).

(v) Senior Care Manager/ Trainer (GS-12 equivalent), COE at WAMC, will serve as a full-time program administrator and trainer of RESPECT-MIL from a systems and interdisciplinary perspective. He or she will be substantially involved in training and consulting on how to implement the overall RESPECT-MIL program at the local level from a systems and interdisciplinary perspective and will monitor the systems/ interdisciplinary implementation of RESPECT-MIL at the local level (i.e., distance supervision).

(vi) RESPECT-MIL Facilitation Educator/Trainer (GS-12 equivalent), COE at WAMC, will serve as a full-time trainer and program manager overseeing the RMF process at the local level. He or she will be substantially involved in training respective discipline members at designated sites and in monitoring and guiding the RMF's implementation of RESPECT-MIL at the local level.

(vii) Program Administrator (GS-12 equivalent), COE at WAMC, will implement and oversee program evaluation processes and related program administrative issues at designated sites.

(viii) Administrative Assistant (GS-9 equivalent), COE at WAMC, will assist the Program Administrator and oversee local unit administrative/resource support issues.

(c) MTF/site level requirements.

(i) RESPECT-MIL Facilitators (RMFs). Licensed Practical Nurses (LPNs) will be located at each of the 15 identified sites. Dependent upon workload and complexity, additional RMFs may be required. Where additional RMFs are required, a Registered Nurse (RN) may be utilized instead of an LPN. RMF's will be contract employees and will manage the care of patients engaged in RESPECT-MIL.

(ii) A Primary Care Physician at each site will serve as site champion for RESPECT-MIL. Primary Care Physician Champions will be identified from organic

assets within each facility. They will train and monitor the performance of all other site Primary Care Providers (PCPs) implementing RESPECT-MIL treatment.

(iii) Behavioral Health Providers (BHPs) identified at each site will serve as BHP Champions for RESPECT-MIL. BHPs will be identified from organic assets at each facility.

(iv) Administrative Assistants will be employed at each site to assist RMFs in administrative processes. They will be contract employees.

(v) Public Affairs Office support (organic assets) to assist with the marketing and awareness campaign at each installation.

(d) AMEDD Center and School (AMEDD C&S), under direction of SGPO, and in consultation with RPD and Family Medicine and Behavioral Health Consultants, will develop a training plan and materials for universal training on depression and PTSD for all Army PCPs.

(8) Legal Considerations. Health Insurance Portability and Accountability Act (HIPAA). RESPECT-MIL operational processes will adhere to patient privacy provisions stipulated in HIPAA.

(9) Deployment is dependent upon development of implementation plans and hiring of personnel.

4. SERVICE SUPPORT.

a. RESPECT-MIL will be funded with Department of the Army Global War on Terrorism (GWOT) funds. Funds will be distributed to applicable MTF Resource Management Offices through the RMCs. MTF Commanders will be responsible for program expenditures. Funds will also be distributed to the COE, Fort Bragg, and the RPD will be responsible for COE expenditures.

b. Requirements:

(1) 3CM ongoing training, traveling for on-site consultation/training, training material development, consultation, and intellectual support.

(2) Travel costs for 30 clinicians, 15 RMFs, and 15 Administrative Champions to travel to a 2-day training workshop at Fort Bragg, early and ongoing RPD and COE travel to designated installations and RMCs for training and staff assistance visits.

(3) Clinician and Soldier education materials, clinician training materials, screening forms, and dissemination of such materials.

(4) Program evaluation services by COE and independent program review.

5. COMMAND AND SIGNAL.

a. Command.

(1) OTSG SGPO will oversee the RPD and relevant RMCs to ensure proper program oversight and monitoring and will provide program direction and guidance.

(2) The COE, directed by RPD, is located at Fort Bragg, NC. Its purpose is to oversee and guide RESPECT-MIL implementation at 15 Army sites across several RMCs. It will do so by providing guidance and direction to RMCs, designated MTFs, and local RESPECT-MIL personnel.

(3) MTF Commanders will be responsible for program implementation at the local level and will report on such to their respective RMCs, which will provide direction and oversight to sites in their region.

b. Signal. Points of contact for this order are:

(1) COL Charles Engel (Dir, DoD Deployment Health Clinical Center at Walter Reed Assoc Prof & Assist Chair (Research) Senior Scientist, Center for the Study of Traumatic Stress Department of Psychiatry F. Edward Hebert School of Medicine Uniformed Services University), at 202-782-8064 (DSN 662) or email: charles.engel@na.amedd.army.mil.

(2) COL Elspeth Cameron Ritchie (Psychiatry Consultant to the US Army Surgeon General) at 703-681-1975 (DSN 761) or email: elspeth.ritchie@amedd.army.mil.

ACKNOWLEDGE:

KILEY
LTG

OFFICIAL:
Patrick O. Wilson
PATRICK O. WILSON
ACS Operations

OPERATION ORDER 07-34 (Re-engineering Systems of the Primary Care Treatment (of Depression and PTSD) in the Military – RESPECT MIL) – USAMEDCOM

ANNEXES:
Annex A (Task Organization) – Not Used
Annex B (Intelligence) – Not Used
Annex C (Operation Overlay) – Not Used
Annex D (Fire Support) – Not Used
Annex E (Rules of Engagement) – Not Used
Annex F (Engineer) – Not Used
Annex G (Air and Missile Defense) – Not Used
Annex H (Command, Control, Communication, and Computer) – Not Used
Annex I (Service Support) – Not Used
Annex J (Nuclear, Biological, and Chemical Operations) – Not Used
Annex K (Provost Marshall) – Not Used
Annex L (Intelligence, Surveillance, and Reconnaissance Operations) – Not Used
Annex M (Rear Area and Base Security) – Not Used
Annex N (Space) – Not Used
Annex O (Army Airspace Command and Control) – Not Used
Annex P (Information Operations) – Not Used
Annex Q (Civil-Military Operations) – Not Used
Annex R (Public Affairs) – Not Used
Annex S (Abbreviations)
Annex T (Dietrich BMJ Publication) *published as a separate PDF file*
Annex U (Oxman 3CM Publication) *published as a separate PDF file*
Annex V (Clinician RESPECT-MIL Manual) *published as a separate PDF file*
Annex W (RESPECT-MIL Facilitator Manual) *published as a separate PDF file*

DISTRIBUTION:
18th MEDCOM
ERMC
GPRMC
MRMC
NARMC
PRMC
SERMC
WRMC
AMEDDC&S
CHPPM
DIR, Health Policy and Services
DIR, Human Resources
DIR, Programs, Analysis, and Evaluations
DIR, Resource Management
POPM

ANNEX S (ABBREVIATIONS) TO OPERATION ORDER 07-34 (Re-engineering Systems of the Primary Care Treatment (of Depression and PTSD) in the Military – RESPECT MIL) - USAMEDCOM

3CM and **3CM Team**: Three component model

AC: Active Component

AD: Active Duty

AMEDD: Army Medical Department

AMEDDC&S: AMEDD Center and School

BHP: Behavioral Health Provider

COE: Center of Excellence for RESPECT-MIL, located at Fort Bragg, NC

GWOT: Global War on Terrorism

LPN: Licensed Practical Nurse

MTF: Medical Treatment Facility

OTSG: Office of the Surgeon General

PCL: PTSD Checklist

PCP: Primary Care Provider

PHQ-9: Patient Health Questionnaire-9

PTSD: Post Traumatic Stress Disorder

RC: Reserve Component

RESPECT-MIL: Re-engineering Systems of the Primary Care Treatment (of depression and PTSD) in the Military

RMC: Regional Medical Command

RMF: RESPECT-MIL Facilitator

RN: Registered Nurse

RPD: RESPECT-MIL Program Director

SGPO: Office of the Surgeon General RESPECT-MIL Project Officer

SOW: Statement of Work

WAMC: Womack Army Medical Clinic, Fort Bragg, NC; where COE is located